



Alice Springs Hospital

12 March 2010

Inquiry into the Child Protection System

Submission on behalf of Alice Springs Hospital

Overarching issues

1. Aboriginal service providers

- If a child falls outside of Aboriginal service providers programs, the child is considered to be outside area of responsibility. It is getting more difficult to refer to some services as they have reduced their scope of service eg Family Nurse Partnership Programme (FNPP) at Central Australian Aboriginal Congress (CAAC) who will only now see women who present prior to 28 weeks gestation and only if this is their first child.
- The providers do not appear to have process for organising the follow up for those it deems to be outside its area of responsibility
- The Aboriginal services can communicate often quite effectively at the individual level (dependant on the individual) but there appears to be little effective communication at the strategic level. eg Congress and Tangentyere.

2. What is the role of the child protection system with respect to child "wellbeing"?

- NTFC do not have appear to have capacity to do any family support work, they are consumed by Child protection issues
- There are often no services in the communities to refer to. NTFC is often the only consistent service provider that attends at remote communities; however they have no capacity to respond to family support issues, difficulties escalate within families as they have no support and inevitably they end up as child protection clients.
- The lack of child health nurse in communities will affect the chronic disease profile of the entire community, especially as chronically sick children grow into unwell adults. This is evidence based.
- The lack of primary health care, health promotion, family education ,family support services. Childcare centres and low school admission adversely contribute to the protection of children. Requires to be more of a primary health care model.

3. Child protection and the *Working Future* policy framework.

We see it as an imperative that decision makers in child protection build strong trusting relationships with families and communities to ensure that decisions are well informed. Evidence shows that community based models of child protection offer the best option for protecting children.

Good to have some kind of child protection service in each community that meet community needs and capacity.

4. Child protection roles and responsibilities of all government and non-government organisations and individuals.

- Remote Area Nurses (RAN) have to prioritise their work. Acutely unwell people are always their priority.
- Too high an expectation on the range and quality of care given by RAN who are generally less qualified in child health than they are in general.
- Recent feedback from trained child health nurses in Ti Tree and Kintore is that they do not have the time to provide the primary health, health promotion activities for children and families in remote communities because of the acute demands on the service. The remote area nurse in Kintore was specifically employed as a Child Health Nurse and was unable to do this work. In Alice Springs there are two key agencies that provide primary health care, parent education, immunisation and well baby clinics. In remote areas where children and families are equally if not more vulnerable these services are not available.
- No central coordination between NGO's and government resulting in system gaps in the coordination and communication between organisations. Often comes down to individual contacts.
- The lack of service provision in remote communities means the hospital is required to take on responsibilities that are outside of its scope.
- Overarching issue is lack of collaboration and communication between the two sectors
- Central Australia child protection workers are too centralised and are not based in remote communities. South Australia placed community engagement and family support officers into communities, moving to a prevention promotion model to child protection. Perhaps DHF could explore the efficacy of this model and determine it's appropriateness for NT.

Recommendation

DHF explore the efficacy of the SA model of community based engagement and family support officers.

Process and system to ensure central coordination between NGO's, NTFC and other government departments.

5. The roles of the two governments

No comments

6. Workforce and workplace issues

- NTFC employees are often on short term contracts, have had minimal orientation and do not have any orientation to the hospital resulting poor communication, misunderstanding, lack of process and inconsistent procedures. This results in the inability to form strong inter professional relationships.
- NTFC workers often have Indigenous studies as part of a degree qualification, they are often accompanied by Aboriginal Community Workers when they are working with Indigenous families. Nevertheless, they only receive one day ACAP training, this is insufficient to ensure they have sufficient knowledge and understanding of the complex cultural issues relevant to Central Australia.

Recommendation –

DHF reinstate the ACAP training to the full three sessions rather than the current one day session that we have – this should be compulsory for all DHF staff

The reinstatement of an Education and Training Officer in the Central Australian region – to co-ordinate NTFC employee training but also to facilitate community education workshops.

Explore the possibility of an NTFC liaison worker to be based at ASH to increase communication/collaboration and enhance working relationships between the two agencies and increase positive outcomes for at risk children and their families

Practices and Systems

1. Intake and assessment system

- Centralisation of NTFC intake has been detrimental. Decisions and prioritisation are made without knowledge of CA area or the families. The NTFC response to notification is often inadequate—no provision of outcome back to hospital. Often health professionals are not informed as to why a notification has been declined.
- Confusion about NTFC intake process – changes are made without knowledge. We have been told of instances where written notifications by organisations are ignored because there has not been a verbal notification.
- An incident where central intake have refused to take a notification because it was a Public Holiday.
- Poor feedback from NTFC re notifications – professionals making notification are often given no response and not involved in ongoing planning. NTFC should use ASH social work as a conduit to share information.
- Poor communication leads to extended length of stay in hospital exposing children to risks and nosocomial infection - difficult for discharge planning and adding to bed pressures.
- High turnover of NTFC staff making it difficult to develop professional relationships, continual revolving door of NTFC staff due to short contract or staff movements throughout the department leads to staff that do not know the processes that are in place. ASH social work department are often unaware of family meetings and they should be conduit to inform other ASH professionals. Inconsistent and / or lack of processes and systems lead to confusion and distress for carers/ families and hospital staff.

- NTFC's lack of follow through and communication makes it difficult for the hospital to determine if a child is being discharged to an unsafe environment.
- NTFC do not share information with ASH clinical and social work staff, but expect ASH to share information at short notice. This appears to reflect poor professional collegiate relationships and respect for others areas of expertise.
- Due to the lack of resources in the remote communities and lack of training and education for remote area staff children at risk are often not identified and /or not reported by the local clinic. This responsibility for notification then falls to ASH.

Recommendations

- The reinstatement of an Education and Training Officer in the Central Australian region – to co-ordinate NTFC employee training but also to facilitate community education workshops around mandatory notification, child protection as a community responsibility and to assist in the develop of effective working relationships between organisations eg facilitate NTFC/Welfare Coalition Protocol training
- Development of guidelines to ensure collaboration between Acute care and NTFC.
- Again, explore the possibility of an NTFC liaison officer based at ASH

2. Out of home care services

- NTFC will leave children in hospital until a place is found – the hospital should not be considered a safe environment. ASH is an acute care facility, we are not able to provide appropriate supervision of children and their families and the risk of nosocomial infection is very high for a well child kept in a hospital environment.
- Anecdotally some foster carers have voiced concerns regarding lack of support, inconsistent NTFC case workers and some have chosen to stop fostering children.
- NTFC does not turn up to collect children when they say they will – often after hours – leaving no support for families upon removal of their children.
- Inconsistent response from different NTFC workers, often not listening to professional opinions from health professionals regarding family dynamics or observations and opinions formed whilst families are inpatients.
- Health professionals need to be informed in advance that a child will be removed so they may help support families through the process.
- Inconsistent processes and systems
- NTFC can appear insensitive to the families and children's emotional and health needs
- No accountability – difficult to provide follow up as ASH often not advised of the movement between carers or reunification with families.
- Not enough foster carers
- Often ASH is unaware of which children are in the Care of the Minister
- Once children are in care there appears to be little capacity for NTFC caseworkers to work towards reunification with families because their time is consumed by child protection matters. There was a Reunification Team in NTFC

whose role was to identify appropriate family members and work with them to assume care of children, this team has been disbanded.

Recommendations

That NTFC implement an alert system, similar to Adult Guardianship, whereby children in the care of the Minister are highlighted on Caresys – this would avoid confusion about who is and who is not in care and increase NTFC participation during hospital admission. This system would require regular updating.

Reinstatement of the Reunification Team to enhance and promote reunification of children with their family.

3. Family support and child wellbeing services (include

- Lack of services available for the child once a notification has been made
- Minimal services in the communities difficult to find out what supports are available.

4. Ongoing case management of and service provision for children, young people and families identified at risk

- NTFC does not provide hospital with details of how to contact the child's carers to initiate follow up and book appointments
- Hospital must send notice of appointments to NTFC, which does not always forward these notices in a timely manner to the carer. Foster care placement and NTFC case management does not guarantee that a child will present for follow up medical care
- Hospital does not know if and when a child is placed into care, or when they leave care. Example: A six year old missed three urologist specialist appointments because the hospital did not know the child was in care.
- ASH will continue to send to NTFC Paediatric or specialist review appointments but these are ignored. ASH presumes that this is a problem within the family but it is not.
- NTFC procedures can at times interfere with a child's medical care. Example: NTFC would not allow a carer to accompany a child to an appointment with a geneticist, thus rendering the consultation ineffective because the carer, who knew the child and her history, was not there to provide the information the geneticist required. The NTFC representative who accompanied the child had no knowledge of the child, and the consultation was incomplete.
- NTFC places children with carers without organising a baseline child health assessment. This could be performed by an identified GP. There is no requirement that this assessment be done by a Paediatrician. ASH does not have the capacity to attend 3/12 health reviews which are the recommended timeframe.
- Lack of coordination and communication when children are removed from their families

- Mother may not be on the ward
 - Mother is not notified
 - Staff are not informed that this is going to happen
 - Staff are at risk of violence
-
- ASH acknowledges the need to remove children from families. However our opinion is that this removal should not occur in the Paediatric or Maternity Wards of ASH. Doing so is very poor practice. It is imperative that NTFC liaises with social work to coordinate and communicate the safe handover of children at an environment external to ASH. ASH as an acute care paediatric facility must be seen as an organisation that it is safe for families to attend. There have been cases where police and security have been called to the Paediatric ward when NTFC have attempted to remove a child from his family's care.
 - No external mechanism or agency monitors or reviews the practice of NTFC. The recent change in legislation meant that the Child Protection Team, with representatives from Education, Health and Police, was disbanded. There is subsequently no external mechanism to review what NTFC are doing or how they are conducting their business.

Recommendation

- That NTFC identify an appropriate GP that can perform general paediatric reviews rather than approaching ASH for this.
- Reinstate Child Protection Team model – ASH would like to have a representative on this team .
- Explore the possibility of a registered child health nurse assigned to NTFC whose job is to coordinate among NTFC and all health services and track children who are in care. This nurse could also perform the initial child health assessment as recommended by the RACP.

5. Legal matters

- ASH treats patients across three states – there appears to be little coordination or cooperation among those three child protection agencies. There is different legislation among the three states that ASH are required to have a working knowledge of. Often there is disagreement among the agencies about whose responsibility a child is, leaving ASH in the middle to attempt safe discharge planning and minimising risk to children on their own. NTFC have been known to fax legal orders to the Paediatric Ward, expecting hospital nurses and social workers to act as process servers. This is inappropriate.
- Despite having Interstate Liaison officers there appears to be little communication between the states child protection authorities.